Testing Available to evaluate for GI causes of Cough:

Upper GI Series: NOT a useful test for reflux (sensitivity 31-86%), only looking for plumbing problems such as malrotation or tracheoesophageal fistula

GE Scan/Milk Scan: NOT useful for reflux (sensitivity 15-59%), OK for aspiration, OK for delays in gastric emptying

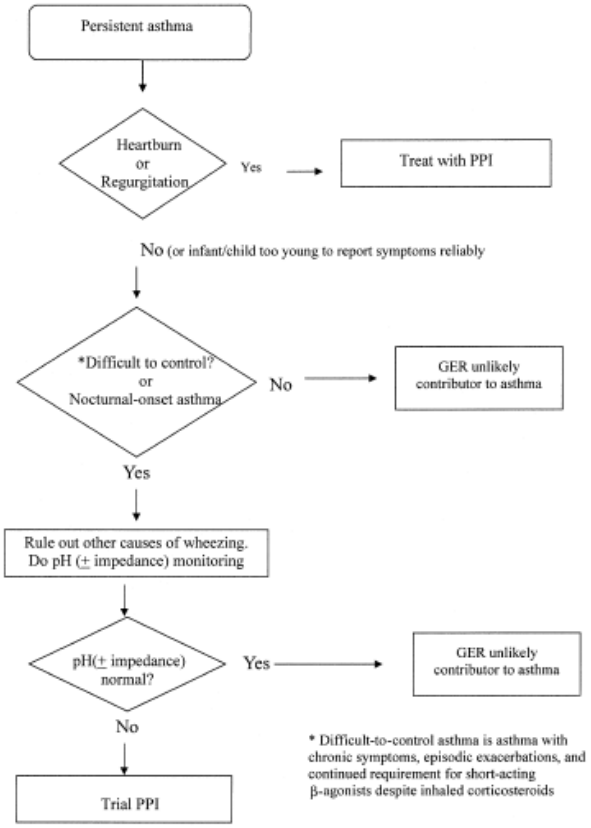
Endoscopy: Earlier studies suggest 95% sensitivity. In age of PPI, may be lower, crucial to make diagnosis of eosinophilic esophagitis which can present with cough

Proton Pump Inhibitor Trial: Sensitivity 78-95%

Impedance Probe: 75-85% Sensitivity

Modified Barium Swallow: NOT for reflux, only for aspiration or abnormalities of the upper esophagus including

Other tests: Motility testing (Achalasia), BRAVO, cough catheter (impedance with pressure sensors), reflux breath testing, restech (probe in posterior pharynx).



AGA Position: Gastro 2008

There is insufficient evidence to recommend for or against PPI therapy for cough but standard or high dose PPI in patients with cough and ESTABLISHED GERD may be beneficial (NNT=5).

There is sufficient evidence to recommend AGAINST acid suppression for asthma and laryngitis in the absence of esophageal symptoms.

NASPGHAN Guidelines 2009

Acid Suppression Pearls:

PPI Dose range: 1-3 mg/kg/day divided QD to BID (check specific meds)
H2 Blockers: 3-4 mg/kg/dose BID (check specific meds)
Metoclopramide: AGA and NASPGHAN "There is evidence to recommend against the use of metoclopramide in the treatment of GERD."
Erythromycin: 1-3 mg/kg/dose TID or QID
Best Tasting: Lansoprazole (prevacid) solutabs, nizatidine (axid)
Children may require BID dosing
Adverse Effects to Discuss: Respiratory infections, diarrhea infections, bone disease, tardive dyskinesia (for metoclopramide)